Watoto Pediatric & Adolescent Specialty, LLC

7915 Lake Manassas Drive, Suite 209
7915 Lake Manassas Dr. Ste #209
Gainesville, VA 20155
Phone: (571) 248-0679 Fax: (571) 261-9549

Request for Medical Records

Please Print Clearly

Names of Children

First Name	**Last Name**	**Date of Birth**
1.		
2.		
3.		
4.		

Type of Records Requested:

- ☐ Immunization History
- ☐ All records
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ ER Reports
- ☐ Specialist Reports
- ☐ Operative Reports
- ☐ Medications
- ☐ Other (Specify)_____

I Authorize Medical Records to be **Released From:**

Name:_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Phone:_____ **Fax:**_____

I Authorize Medical Records to be **Transferred To:**

Watoto Pediatric & Adolescent Specialty

7915 Lake Manassas Dr. Ste #209
Gainesville, VA 20155
Phone: (571) 248-0679 Fax: (571) 261-9549

I hereby authorize disclosure of health information related to sexually transmitted disease, AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus), behavioral or mental health services, and treatment for alcohol and drug abuse. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person in facility receiving it and would then no longer be protected by federal regulations.

_____

Parent or Legal Guardian (Please Print)

_____

Parent or Legal Guardian Signature Date